

A **“how-to  
guide”** for a  
**sexual health  
check-up**

*Good sexual health is about achieving both physical and psychological wellbeing, free from disease, coercion or abuse. Reaching and maintaining good sexual health requires a positive and respectful approach to sex and sexual relationships, as well as the ability to have pleasurable and safe sexual experiences. Primary care plays an important role in the provision of all aspects of sexual health care, including educating about sexually transmitted infections (STIs) and safer sex and providing testing and treatment for STIs.*

## **New Zealand has a high rate of sexually transmitted infections**

In New Zealand, the prevalence of bacterial sexually transmitted infections (STIs), e.g. chlamydia and gonorrhoea, is high compared to other developed nations, such as Australia and the United Kingdom. Chlamydia is the most commonly reported STI in New Zealand, with a reported incidence in 2011 of 786 new cases per 100 000 people.<sup>1</sup> More than 70% of reported chlamydia infections occurred in people aged 15 – 24 years,<sup>1</sup> and the number of diagnoses in community laboratories in females was 2.8 times higher than in males (indicating significantly greater uptake of STI testing in females).<sup>1</sup> Gonorrhoea is the second most commonly reported STI, with an incidence of 67 cases per 100 000 people, followed by genital warts, genital herpes, non-specific urethritis and syphilis.<sup>1</sup> The prevalence of chlamydia and gonorrhoea is higher in Māori and Pacific Peoples and in people aged under 25 years.<sup>1</sup> Syphilis is much more commonly diagnosed in men who have sex with men (MSM), accounting for 83% of cases diagnosed in sexual health clinics in 2011.<sup>2</sup> The prevalence of viral STIs such as human papillomavirus (HPV) and herpes simplex virus is less well known, as most infections are asymptomatic.

There are multiple cultural, behavioural and economic factors contributing to current disparities in sexual health indices in different population groups in New Zealand. Primary care is ideally situated to address these issues by improving the sexual health knowledge of patients and facilitating the diagnosis and treatment of STIs.

## **When should you take a sexual health history?**

Questions about sexual health should be routinely included as part of a general history for all patients seen in primary care. The purpose of taking a sexual health history is to assess risk of STIs, identify problems with sexual function, identify issues of past sexual abuse or risk of future abuse, and to assess overall sexual wellbeing and knowledge.<sup>3</sup>

In general, a sexual health check should be undertaken:

- As part of a routine preventative healthcare check-up in all sexually active people (particularly those aged under 25 years)<sup>4</sup>
- For sexual contacts of someone with a bacterial STI, pelvic inflammatory disease or epididymo-orchitis
- For people who have had a recent partner change or multiple partners
- For females attending for routine contraceptive or cervical screening visits
- Prior to intrauterine device (IUD) insertion
- During routine antenatal testing
- Before termination of a pregnancy
- For people presenting with specific anogenital symptoms
- For people who have been sexually assaulted
- For people who request a sexual health check

## How to open a dialogue about sexual history

Ensure that the patient feels comfortable and able to speak openly. It is important that practitioners are also comfortable with asking questions about sexual health in order to help put patients at ease. It should be clear from the outset that the consultation is confidential, and the tone of the conversation should aim to normalise the clinical encounter, e.g. *"We routinely discuss sexual health with all our patients, is it ok if I ask you some questions?"* or: *"Chlamydia is very common in sexually active young people, so can I ask you some questions to see if you need a check-up?"*

## General points for taking a sexual history

All questions in the sexual history should be gender neutral until the gender of sexual contacts is known. Avoid using the term "partner" (or husband/wife) unless the person has stated they are in a relationship.

It is important to discuss confidentiality, and its limitations, in case any significant safety issues are identified.

It may be helpful to briefly explain why each question is being asked and that the questions are routine, e.g. *"We ask everyone the same questions, they may seem intrusive but I'm just trying to find out risks and what tests you may need."*

It may not be possible to take a full sexual history at the initial presentation, especially if this was not the primary reason for the visit. The most relevant information is whether the patient is currently symptomatic, whether any test is indicated at that visit, whether they are at risk of unwanted pregnancy and whether they have risk factors for HIV, syphilis, hepatitis or other infections. Asymptomatic, young people can be referred to the Practice Nurse for a more in-depth sexual health history and testing if there is insufficient time during the consultation, or be encouraged to return for an additional consultation. New Zealand research shows that nurse-led education and self-collection of samples is an effective strategy for increasing uptake of opportunistic chlamydia testing in people aged 16 – 24 years.<sup>5</sup>

The range of questions that may be included as part of a complete sexual history are:<sup>3</sup>

- Do you have any specific problems or symptoms?  
Mention specific symptoms such as, for females: unusual vaginal discharge, lower abdominal pain, abnormal bleeding, urinary symptoms and dyspareunia; for males: dysuria, penile discharge; and for both sexes: genital itch, rashes, sores or blisters, anorectal symptoms.

- Are you sexually active at present? Are you in a relationship?
- When was the last time you had sex? (important to establish whether it is an appropriate time to test)
- Was this with a regular or casual sexual contact/partner?
- Was this sexual contact/partner male or female?
- Do sexual encounters usually include vaginal, oral or anal sex?
- How many sexual contacts/partners have you had in the previous two months? (important for partner notification purposes)
- Do you use condoms – always, sometimes or never?\*
- For females – when was your last period? Do you use hormonal contraception? When was your last cervical smear?\*\*\*
- Have you ever had any STIs before?
- Have you had all your routine recommended vaccinations? e.g. Hepatitis B, HPV?\*\*\*
- Do you ever have sex while under the influence of alcohol or other drugs? Have you ever injected drugs?
- Have you ever traded sex for money or drugs?
- Have you ever had any unwanted sexual contact?
- Have you ever been afraid in a relationship, or been hurt by a partner?
- Have you ever had a non-professional tattoo, genital piercing, or received medical or dental treatment overseas in a developing nation? (important to assess risk of blood-borne viruses)

Once relevant information has been gathered, ask again if the patient has any questions or if they want to add anything before assessing their risk of infection.

\* Modify to "protection" for women who exclusively have sex with women

\*\* If thorough patient notes are available, hormonal contraception use, cervical smear information and vaccination questions may be skipped

## Assess the patient's risk profile for STIs

The key behaviours that increase risk of any STIs are:<sup>6</sup>

- Misuse of alcohol or other recreational drugs
- Early onset of sexual activity
- Inconsistent condom use
- Multiple or frequent change of sexual contacts (more than ten in the previous six months)
- A history of sexual assault or intimate partner abuse

- Commercial sex work (if not using condoms consistently), or having unprotected sex with a commercial sex worker

The key groups at risk of HIV are:<sup>6</sup>

- Men who have sex with men (MSM)
- People from a country where there is a high HIV prevalence, e.g. Sub-Saharan Africa, South-East Asia, India, Eastern Europe, South America
- Injecting drug users
- Sexual partners of people in the above categories

People at increased risk of blood-borne infections, e.g. hepatitis C, include:<sup>3</sup>



- Injecting drug users – past or present
- HIV positive MSM
- People who have received medical or dental treatment in a developing nation
- People who have had non-professional tattooing or piercing

## Physical examination and appropriate testing

The information gained from the sexual history will guide the extent of physical examination and laboratory testing required.

Generally, routine STI testing should occur annually where appropriate, but this depends on risk factors. Testing should be repeated more frequently (i.e. three to six monthly) if the patient's history suggests higher risk sexual behaviours.

If there is a specific sexual event that the patient is concerned about and they are currently asymptomatic then it is recommended that testing be deferred until two weeks after the event. If they are unlikely to come back for testing or if they have current anogenital symptoms then testing should be done at the time of presentation.

 Any patient with atypical anogenital ulceration should be referred to or discussed with a sexual health physician  for further information see New Zealand Sexual Health Society genital ulcer disease summary: [www.nzshs.org](http://www.nzshs.org).

STI test availability varies throughout New Zealand, and testing should always be guided by local laboratory recommendations. Most laboratories now offer combined nucleic acid amplification tests (NAAT) for chlamydia and gonorrhoea on a single PCR swab or urine specimen (talk to your laboratory about the preferred specimen collection swab/receptacle).

## Give advice about safer, healthier sex

Individualised advice should be given about practising safer and healthier sex, based on information gained from the patient's sexual history.

Consistently and correctly using condoms is the most important advice for reducing the risk of pregnancy and STIs. It is recommended that a water-based lubricant is used with condoms to reduce risk of breakage during vaginal or anal sex. Thicker condoms do not offer any additional protection against STIs and HIV.<sup>7</sup> Discuss the use of the emergency contraceptive pill with women who are not using other forms of contraception. This can be prescribed by a clinician or purchased from an accredited pharmacist in a community pharmacy.

Advice on condom use can be excluded in women who have sex exclusively with women, although other methods of STI protection and not sharing sex toys, should be suggested.<sup>7</sup>

Talking about alcohol and drug use is recommended, particularly in younger people, as this may predispose them to higher-risk sexual behaviours such as unprotected sex.<sup>7</sup> Offer information on local drug and alcohol counselling services if appropriate.

Traditionally, advice on safer sex included abstinence. There is now a large body of evidence showing that the promotion of abstinence has no benefit in preventing unintended pregnancy and STIs.<sup>7</sup> Therefore, abstinence should only be discussed as one of a range of strategies to reduce risk.<sup>7</sup>

Ideally, an examination should be performed as part of a sexual health check-up, and samples for testing taken during the examination. However, self-testing is a safe and effective method for opportunistic testing in asymptomatic patients or those who decline examination.<sup>8,9</sup>

It is important to tell patients how and when they will be notified of test results. For low-risk patients it is usually appropriate to tell them that they will only be contacted if there are any abnormal results. For higher risk patients, e.g. MSM having unprotected anal sex, it is recommended that they are asked to re-attend to discuss their results in person.

## Females

Routine examination and testing for females should include:<sup>3</sup>

- Physical examination of the vulval and perianal skin, inguinal nodes, vestibule, introitus, cervix and vagina, looking for skin lesions, rashes, ulceration and abnormal vaginal discharge
- If requiring speculum examination, i.e. symptomatic or a contact of a person with gonorrhoea:
  - Endocervical swab(s) for chlamydia and gonorrhoea testing (one swab if the laboratory offers combined NAAT testing)
  - If a sexual contact of someone with gonorrhoea an additional endocervical swab for culture and antibiotic susceptibility testing should be taken\*
  - High vaginal swab for bacterial vaginosis, candida, and trichomoniasis
- Serology for hepatitis B (if not immunised), syphilis and HIV
- Hepatitis C serology if the patient has risk factors
- Viral swab for herpes simplex virus if ulcers are present

A self-collected vaginal swab is appropriate for opportunistic testing for chlamydia in an asymptomatic female, or if a genital examination is declined. Instruct the patient to remove the swab from its container, insert it approximately 4 cm into the vagina, rotate and then replace in the swab container.

A first void urine (first 30 mL of the stream) is not the first-line recommendation for chlamydia testing in women as it has lower sensitivity than a vaginal swab, but is useful if the patient declines examination and does not want to self-collect a swab.

## Males

Routine examination and testing in males should include:<sup>3</sup>

- Physical examination of the genital and perianal skin, inguinal lymph nodes, penis, scrotum, and testes looking for skin lesions, urethral discharge, rashes and genital ulceration
- First void urine for chlamydia testing (and gonorrhoea if the laboratory offers combined NAAT testing)
- If symptomatic with dysuria, urethral itch or discharge, or urethral discharge is noted on examination or a contact of a person with gonorrhoea:
  - Take a urethral swab for gonorrhoea culture,\* using the smallest available bacterial culture swab (e.g. thin, blue per-nasal swab inserted approximately 1 cm into the urethral canal)
- Serology for hepatitis B (if not immunised), syphilis, and HIV
- Hepatitis C serology if the patient has risk factors
- Viral swab for herpes simplex virus if ulcers are present

N.B. Urine samples do not have to be early morning urine. Ideally the patient should not have passed urine in the previous two hours, however, if the patient is unlikely to return for testing, a specimen should still be collected and tested. A study has shown that the voiding interval does not significantly alter results of the Cobas PCR assay when testing for chlamydia in males.<sup>10</sup>

## Men who have sex with men (MSM)

Testing as recommended for all males should be offered at least annually, depending on sexual history. Additional tests, regardless of stated sexual practices, should also be included for MSM.

N.B. MSM with anorectal symptoms should be referred to, or discussed with, a sexual health physician.

**Additional** tests (i.e. also follow recommendations for all males) for MSM include:<sup>3</sup>

- A pharyngeal NAAT test for gonorrhoea
- An anorectal NAAT test for chlamydia and gonorrhoea. Anorectal swabs should be collected by inserting the


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\* Discuss with laboratory as swabs for gonorrhoea culture are not always processed (or are subject to specific criteria)

swab 4 cm into the anal canal, rotating and replacing in the swab container. If the patient is a sexual contact of a person with gonorrhoea, an additional anorectal swab for gonorrhoea culture\* and antibiotic susceptibility testing should be taken.

- Hepatitis A serology (if not immunised) – offer vaccination if susceptible (not funded; once a patient is recorded as having been vaccinated, annual testing is no longer required)

N.B. NAAT tests are now recommended for testing rectal and pharyngeal infection in MSM. A positive NAAT test from an extra-genital site needs to be confirmed by supplementary testing, which is done automatically by the laboratory.<sup>11</sup>

 **Best Practice Tip:** Test kits can be bundled up and tied with a band in groups for a “male check-up”, “female check-up” and “MSM check-up” to help speed up the testing process and ensure that all the necessary tests are done.

## Treatment of common STIs

Treatment should be initiated if testing reveals a positive result for an STI, or if there is a high index of suspicion, e.g. signs and symptoms or contact with a person with a confirmed STI.

Patients should be advised to avoid unprotected sexual intercourse until seven days after treatment has been initiated for any STI, and at least seven days after sexual contacts have been treated, to reduce risk of re-infection. Partner notification should be discussed at the time of treatment (see “Partner notification”).

**All patients should be routinely followed up one week after treatment to check adherence, symptom resolution and whether partner notification has occurred.** This role is often undertaken by the Practice Nurse. Re-treatment is necessary if there has been unprotected sex with untreated sexual contacts during the week after treatment initiation. Patients should be advised to have a repeat sexual health check in three months, as reinfection is common. Entering a recall in the practice management system can be helpful.

## Referral may be necessary

Referral to, or discussion with, a sexual health physician is recommended for patients with:<sup>12</sup>

- Recurrent urethritis
- Genital warts (difficult or resistant cases)

## Partner notification

Partner notification, or contact tracing, is the process of identifying sexual contacts of a person with a STI and ensuring that they are aware of their possible exposure. This helps to prevent reinfection in the index case, and allows identification of undiagnosed STIs and prevention of possible complications in their contacts. Partner notification should be discussed at the time of treatment for a STI and is recommended when the following conditions are identified: chlamydia, gonorrhoea, trichomoniasis, non-gonococcal urethritis, pelvic inflammatory disease and epididymo-orchitis. Partner notification is not necessary for people diagnosed with genital warts or genital herpes although regular sexual partners may benefit from an assessment and a routine sexual health check. Management of partner notification for syphilis or HIV is more complex and referral to, or discussion with, a sexual health physician is recommended.

The most common method of partner notification is for the index case to notify their sexual contacts themselves.<sup>13</sup> All sexual contacts in the previous two months should be notified.<sup>13, 14</sup> Discuss with the patient how they will notify their contacts, e.g. in person or over the phone, email or text, and provide them with the information that they will need, such as fact sheets and suitable websites on the condition and advice on returning for testing.<sup>13</sup>

If the patient does not wish to notify their contacts due to concerns about confidentiality or safety, e.g. there are issues of partner violence, notification can be done by clinical staff, with every effort to maintain confidentiality of the index case. If a patient attends as a contact of someone who has been infected, the index case must not be identified to the contact. Referral to appropriate agencies should be facilitated if there is ongoing risk of violence from a current relationship.


The General Practitioner, or usually the Practice Nurse, should follow up with the patient after one week to confirm that relevant sexual contacts have been notified, as well as to check symptom resolution, adherence to medication and whether there has been any unprotected sex.<sup>13</sup>

Sexual health clinics can assist with partner notification if required.

- Suspected or confirmed syphilis
- Suspected or confirmed HIV
- Any STI during pregnancy
- Problematic, recurrent or chronic vaginal discharge
- Chronic genital pain or sexual dysfunction

Referral is also needed for patients who require specific sexual health counselling, or for follow-up of patients or contacts who fail to attend for treatment.

In New Zealand some conditions must be reported to the Medical Officer of Health, including acute hepatitis A, B and C and AIDS (but not HIV).

 For more detailed information on the treatment of STIs, refer to the New Zealand Sexual Health Society Best Practice Guidelines, available from: [www.nzshs.org](http://www.nzshs.org)

## Chlamydia

The first-line recommended treatment for people with chlamydia (and males with non-gonococcal urethritis), and their sexual partners is azithromycin 1 g, stat, or alternatively (if not pregnant), doxycycline 100 mg, twice daily, for seven days.

Azithromycin is safe for use in women who are pregnant (category B1\*),<sup>15</sup> and has better efficacy than alternatives.

\* Therapeutic Goods Administration Australia pregnancy category

Patients with a symptomatic rectal chlamydia infection, should be referred to, or discussed with, a sexual health physician.<sup>16</sup>

All patients treated for chlamydia and gonorrhoea should be advised to have a repeat sexual health check in three months, as re-infection is common. A test of cure is unnecessary, except in women treated during pregnancy or if a non-standard treatment has been used. This should be carried out five weeks after treatment was initiated.<sup>16</sup>

## Gonorrhoea

The first-line recommended treatment for people with gonorrhoea, and their sexual partners is ceftriaxone 500 mg, IM, stat (make up with 2 mL lignocaine 1%, also see "Updated guidance on using ceftriaxone"), **plus** azithromycin 1 g, stat. Co-infection with chlamydia is very common, and azithromycin should always be co-administered, even if the chlamydia test is negative as the medicines act synergistically and reduce the risk of development of resistance.<sup>17</sup>

If the isolate is known to be ciprofloxacin sensitive, a 500 mg stat dose of ciprofloxacin can be used instead of ceftriaxone (but not in women who are pregnant).

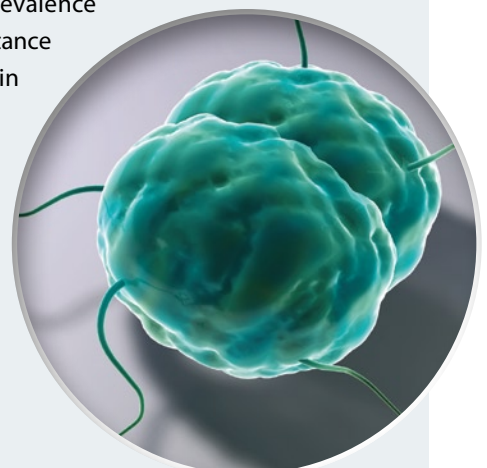
A test of cure for gonorrhoea is not usually required unless there is a risk of re-exposure, symptoms do not resolve or a non-standard first-line medicine has been used (test in five weeks). Patients should be encouraged to return in three months for a sexual health check.<sup>17</sup>

## Updated guidance on using ceftriaxone to treat gonorrhoea

Ceftriaxone injection is used for treating gonorrhoea if the antibiotic susceptibility is unknown, if the isolate is ciprofloxacin resistant, and for females who are pregnant or breast feeding (ciprofloxacin is contraindicated in pregnancy). The recommended dose of ceftriaxone for the treatment of gonorrhoea has increased from 250 mg ceftriaxone IM, to 500 mg IM stat.<sup>17</sup>

This increase in the dose for ceftriaxone has been recommended to overcome emerging cephalosporin resistance in *Neisseria gonorrhoeae*. Although the relevant subsidy requirement for ceftriaxone is "treatment of

confirmed ciprofloxacin-resistant gonorrhoea", the prevalence of ciprofloxacin resistance is as high as 54% in some areas in New Zealand, and treatment where susceptibility is not known should be with ceftriaxone.<sup>17</sup>



## Trichomoniasis

The first-line recommended treatment for people with trichomoniasis, and their sexual partners is metronidazole 2 g, stat, or alternatively if not tolerated, metronidazole 400 mg, twice daily, for seven days. Metronidazole may be given to women who are pregnant (category B2) or breast feeding, but they should be advised to avoid breast feeding for 12 – 24 hours after the dose.<sup>18</sup> Ornidazole 1.5 g, stat may be used instead of metronidazole, but is not recommended in women who are pregnant as no study data is available.

A test of cure for trichomoniasis is not usually required unless there is a risk of re-exposure. Culture of urethral swabs is rarely positive in males, due to low sensitivity, therefore empirical treatment of male partners is recommended without testing for trichomoniasis. Male contacts should, however, have a routine sexual health check for other STIs.<sup>18</sup>

## Bacterial vaginosis

Women with bacterial vaginosis are often asymptomatic. It is not usually necessary to treat bacterial vaginosis unless symptoms are present or an invasive procedure is planned, e.g. insertion of an IUD or termination of pregnancy.

If treatment is required, first-line is metronidazole 400 mg, twice daily, for seven days.<sup>19</sup> Metronidazole 2 g stat, may be given if adherence is an issue, however, the stat dose is thought to be associated with a higher rate of relapse in women with bacterial vaginosis. Ornidazole 500 mg, twice daily, for five days, or 1.5 g, stat, is an alternative if metronidazole cannot be tolerated.

Treatment of male sexual partners of women with bacterial vaginosis is not usually necessary.

## Pelvic inflammatory disease

Pelvic inflammatory disease (PID) is usually caused by a STI, particularly in women aged under 25 years, women who have had recent change of sexual partner or women with a previous history of gonorrhoea or chlamydia. Diagnosis of PID is clinical, taking into account the history, clinical findings and results of tests. However, STI tests will often be negative and a low threshold for treatment is appropriate, given the potential long-term consequences of infection and diagnostic uncertainty. Treatment should cover infection with gonorrhoea, chlamydia and anaerobes.

First-line treatment is ceftriaxone 500 mg, IM, stat **plus** doxycycline 100 mg, twice daily, for 14 days **plus** metronidazole

400 mg, twice daily, for 14 days. Metronidazole can be discontinued in women with mild PID symptoms, if it is not tolerated.<sup>20</sup>

Note: If adherence is in doubt, azithromycin 1 g stat, with a repeat dose in seven days, may be used instead of doxycycline.<sup>20</sup> Ornidazole may also be considered as an alternative to metronidazole, if it is not tolerated.

## Epididymo-orchitis

Epididymo-orchitis may occur due to a variety of pathogens. STI pathogens are more likely in younger males (< 35 years) with a history of more than one sexual partner in the past 12 months and urethral discharge.<sup>21</sup> It is important to test for STIs prior to initiating antimicrobial treatment.

If STI pathogens are suspected as the cause, first-line treatment is ceftriaxone 500 mg IM, stat, followed by doxycycline 100 mg, twice daily, for 14 days. If symptoms are severe, refer immediately to hospital.<sup>21</sup>


If UTI pathogens are suspected as the cause, first-line treatment is ciprofloxacin 500 mg, twice daily, for 10 days or (if contraindications to quinolones) amoxicillin clavulanate 500/125 mg, three times daily, for 10 days.

Patients should be reviewed within 24 – 48 hours to assess response to treatment, and should be referred to hospital (urology) if signs and symptoms are worsening or do not improve.<sup>21</sup>

## Genital herpes

Lesions (genital ulcers, sores or fissures) may be detected during the physical examination. If there is uncertainty, refer to, or discuss with, a sexual health physician. Referral is recommended for women who have their first clinical episode during pregnancy as serology may be required. A viral swab of lesions for herpes simplex should be taken, but a negative result does not exclude infection.<sup>22</sup>

The recommended first-line treatment is aciclovir 200 mg, five times daily, or 400 mg, three times daily, for five days (safe to use during pregnancy).<sup>15</sup> Lignocaine gel 2% may be given for topical analgesia (not subsidised), but oral analgesia may be required, particularly if symptoms are severe.<sup>22</sup>

 For further resources on managing herpes, including in women who are pregnant, see: [www.herpes.org.nz](http://www.herpes.org.nz)



## Genital warts

Lesions can be identified on clinical examination. If warts are extensive, atypical, intravaginal/cervical or if there is uncertainty about the diagnosis, refer to, or discuss with, a sexual health physician.<sup>23</sup>


Treatment is mainly for cosmetic purposes, and may not be desired in all cases, e.g. if the warts are not visible externally and not extensive.

Podophyllotoxin solution 0.5%, twice daily, for three consecutive days per week, for five weeks, is appropriate for lesions which can be easily seen, e.g. pubic or penile shaft warts. It is not recommended to use podophyllotoxin for females with vulval warts or for people with perianal warts, as misapplication will cause significant irritation.

Imiquimod cream 5%, once daily, three times per week, for up to 16 weeks, is fully subsidised with Special Authority, for patients with warts not responsive to podophyllotoxin or for use in more sensitive areas, e.g. vulval or perianal warts or warts under the foreskin.<sup>23</sup>


Cryotherapy, laser, diathermy or surgical excision may be options if other treatments are not effective.<sup>23</sup>

N.B. The HPV vaccine prevents infection with HPV types 6 and 11 which cause 90% of anogenital warts.<sup>23</sup>

 For further resources on managing HPV, including in women who are pregnant, see: [www.hpv.org.nz](http://www.hpv.org.nz)

## Syphilis


It is recommended that all patients with suspected syphilis be referred to, or discussed with, a specialist sexual health service if the practitioner does not have experience in managing syphilis.


 For further information see: "Syphilis: testing for the great imitator", Best Tests (Jun, 2012).

## What to do if other sexual health issues are raised

Occasionally in the course of a sexual health consultation a patient may state or indicate that they have sexual health issues beyond disease or infection.


**Sexual dysfunction** such as erectile dysfunction or loss of libido, are likely to be the most common non-STI issues encountered in primary care. A key requirement for the evaluation of sexual dysfunction is to determine whether the issue is associated with stress or anxiety. The presence of any serious medical condition is likely to impair sexual function not only because of the condition itself, but also due to the associated impact on psychological wellbeing.

 For further information on sexual dysfunction in women, see "Selected topics in women's health", Best Tests (Sept, 2010).

 For further information on sexual dysfunction in men, see "Selected topics in men's health", Best Tests (Sept, 2010).

**Sexual violence** is common in New Zealand. Most offenders are known to the victim and there is a high rate of intimate partner violence in New Zealand. Identifying people who are currently experiencing abuse or have been recently abused is likely to be difficult and will rely on interpreting the person's responses to sexual history questions and explicitly asking about abuse. These people will usually require referral to the appropriate services and if there are children in the household who are witnessing violence then referral to Child Youth and Family Services (CYFS) is required.

It is important to be aware of what counselling support services are available locally. Counselling may be funded by ACC. People who disclose a recent sexual assault may wish to report it to the police and a forensic examination may be required. Doctors for Sexual Abuse Care (DSAC) is an organisation that provides advice and support on the management of sexual abuse to New Zealand doctors. DSAC provides guidelines and an educational service, as well as patient information.

 For further information, see: [www.dsac.org.nz](http://www.dsac.org.nz)



# Selected topics in sexual health

## Special consideration for people who are lesbian, gay, bisexual and transgender

Lesbian, gay, bisexual and transgender (LGBT) people have different risks from those seen in the majority of patients. There is a large body of evidence that LGBT people are likely to report greater perceived barriers to quality healthcare as a direct result of their sexual or gender identity.<sup>24</sup> Asking about sexual preference during a sexual health consultation provides an ideal way in which to broach the subject in order to offer better care.

The uptake and frequency of cervical cancer screening is significantly lower in females who identify as lesbian or bisexual (ten times less likely to have had a test in the previous three years) than in heterosexual females.<sup>24</sup> Cervical cancer is caused by sexually transmitted high-risk HPV types, and there may be a false perception among both patients and healthcare providers, that women who do not have penetrative sex with males are not at risk from cervical cancer. However, there is significant clinical evidence that HPV is easily transmitted by oral sex and digital penetration. Health care providers should encourage cervical screening in all females aged 20 years and over, regardless of sexual preference or identity, and routine STI testing should be offered to all sexually active women regardless of sexual preferences.

Men who have sex with men have different sexual health risk factors than exclusively heterosexual men. HIV and syphilis are more common in MSM, and STIs such as gonorrhoea and syphilis can easily be transmitted by oral sex. Encouraging the use of condoms, and assessing recreational drug and alcohol use in this group is particularly important. Regular testing for STIs is recommended at least annually, with more regular testing depending on sexual history, rate of partner change and consistency of condom use.<sup>25</sup> Frequent testing (three to six monthly) is recommended for men reporting regular, unprotected anal sex, more than ten sexual partners in six months, engagement in group sex or use of recreational drugs during sex.<sup>25, 26</sup> Testing for syphilis at least annually is recommended in HIV-positive MSM.<sup>25</sup>

Some patients may express concern over certain problems believed to be related to anal sex, such as piles and anal fissures; however, these issues are no more common in MSM than in heterosexual people.<sup>27</sup> These problems are usually related to straining at stool or constipation, and should be managed within this context (see "Anal Fissures", Page 16). Faecal-oral spread of illnesses such as giardiasis and hepatitis A can occur via oral-anal sexual contact. Episodes of diarrhoea may be due to faecal exposure via oral-anal contact with another person, but are usually self-limiting. If diarrhoea persists, stool culture should be requested to identify any potential bacterial cause.<sup>27</sup> STIs such as chlamydia, gonorrhoea, herpes and syphilis may cause symptoms of proctitis (anal bleeding, discharge and tenesmus) even if there is no history of receptive anal intercourse. Therefore it is recommended that all MSM with anorectal symptoms be referred to or discussed with a sexual health physician.

Homosexuality and bisexuality, of both men and women, has been associated with higher rates of psychological and behavioural disorders, including depression, anxiety, mood disorders, suicidal ideation and planning, eating disorders, alcohol and substance abuse, and tobacco use.<sup>28</sup> While these issues are not exclusively related to sexual health, identifying a same-sex or bisexual sexual identity in a sexual health consultation presents an opportunity for the practitioner to discuss these other significant issues.

## Ensuring the safety and health of sex workers

Sex workers, both male and female, have high-risk lifestyles and, as a group, are often marginalised by society. In general, sex workers exhibit higher than average knowledge about STI and HIV transmission.<sup>29</sup> Sex workers self-report an overall high adherence rate to condom-use, safe sex practices and health-seeking behaviours.<sup>29</sup> However, sex workers often have poor control over work-place safety and may not have complete





control over safe-sex practices; condom use may be poor in certain circumstances, particularly where there is concurrent drug or alcohol use.<sup>29</sup> In addition, rates of abuse, sexual assault and psychological issues are higher among sex workers than in the general population.<sup>29</sup>

When assessing the health of sex workers, include questions about intravenous drug use and exposure to abuse.

Six-monthly screening for STIs and HIV is sufficient for sex workers; more regular testing does not increase STI prevention if condoms are used consistently.<sup>30</sup>

Assessing the mental health of sex workers is important, both directly and indirectly as a method of preventing further sexual health issues. Sex workers who are psychologically distressed or have identified mental health issues report less consistent condom use, riskier behaviour and fewer sexual health check-ups.<sup>29</sup>

 For further information and a resource to which sex workers can be directed, see: [www.scarletalliance.org.au](http://www.scarletalliance.org.au) and [www.nzpc.org.nz](http://www.nzpc.org.nz)

 For further information on what to do in the case of sexual abuse or exploitation, see: [www.dsac.org.nz](http://www.dsac.org.nz)

## Genital piercing and STIs

Performing a sexual health check-up in a person with a genital piercing may be difficult: physically, it may be complicated to obtain urethral swabs, and certain piercing locations may increase the risk of blood borne infection.

Male genital piercing, most commonly through the glans penis and external urethra, known as a “Prince Albert”, can cause scarring and urinary problems. As urethral swabs in males are inserted one centimetre into the urethra, some piercings may affect testing. First void urine is unlikely to be affected. Female genital piercing is usually through the clitoris, clitoral hood or labia, and it is therefore unlikely to impact on examination or swab collection.

Genital piercing, like any procedure that penetrates the skin, can lead to a viral or bacterial infection. Post-procedural infection with bacteria, such as *Staphylococcus aureus*, *Pseudomonas* and group A streptococcus, is common.<sup>31</sup> There is limited evidence as to whether the prevalence of STIs is increased in people with genital piercings. In general, genital piercing in females, unless at a non-typical site, is unlikely to directly affect STI prevalence or exposure. However, there is case study evidence that the prevalence of genital warts is higher in males with genital piercings.<sup>31</sup> This may be causative, as the trauma and epithelial damage from piercing may increase the ease of transmission of high-risk HPV strains, or correlative, in that males with genital piercing may be prone to higher-risk behaviours.<sup>31</sup>

Important information may be revealed by enquiring about the reason for getting a piercing. Genital piercing in females has been linked with an increased incidence of past physical, emotional and sexual abuse (this link has not been studied in males).<sup>32</sup> In many of these females, genital piercing was viewed as a way to reclaim their bodies or their sexuality.<sup>32</sup> While the absolute number of females with genital piercing who have been exposed to abuse is likely to be low, the relative number appears to be high compared to the overall population.

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